Requester: Fill Out to Receive Requested Information Expeditiously.

Notify: _____

Location: _____

NOTE: THIS FORM IS TO BE USED TO **OBTAIN** MEDICAL RECORD INFORMATION **FROM** OTHER AGENCIES.

_____ _____

Patient's Name Date of Birth

I hereby request and authorize: _____

_____

_____

to release information to: Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226

The purpose for releasing these records is _____

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

The specific and relevant information I wish to release is:

_____ Discharge Summaries

_____ PCS Intake

_____ History & Physical

_____ Psychiatric/Psychological Evaluations

_____ Social Service Data Bases

_____ Treatment Plans

_____ Lab/Radiology

_____ Outpatient Assessments/Evaluations

_____ Outpatient Progress Notes/Treatment Plans

_____ Other (specify) _____

for the treatment period of (list approximate dates): _____

I understand that I may revoke this consent at any time by written notification except to the extent that action has been taken in reliance on it, and that in any event, this consent will expire one year from the date of signature unless an otherwise stated date, event or condition is stated here _____

A photocopy or facsimile of this authorization shall be as valid as the original.

PROHIBITION ON DISCLOSURE (for Alcohol and Drug Abuse records): This information is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. I also understand that I may inspect and, upon payment of the usual fee, receive a copy of the released information, and that I may receive a copy of this intended consent form.

Conditions: This authorization is voluntary. BHD will not condition your treatment on this authorization.

Effect of Granting This Authorization: The protected health information described above may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

_____ _____

Signature of Patient Person Authorized To Consent For Patient

_____ Date: _____

Date

_____ Relationship _____

Witness (Legal documentation of relationship required)

Reason: _____

BEHAVIORAL HEALTH DIVISION
Milwaukee, Wisconsin 53226

2190 R8
Rev. 01/06

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

NOTE: THIS FORM IS TO BE USED TO **RELEASE** MEDICAL RECORD INFORMATION **FROM** THE BEHAVIORAL HEALTH DIVISION

Patient's Name _____ Date of Birth _____

I hereby request and authorize: Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226

to release information to: _____

_____

_____

The purpose for releasing these records is _____

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

The specific and relevant information I wish to release is:

_____ Discharge Summaries
_____ PCS Intake
_____ History & Physical
_____ Psychiatric/Psychological Evaluations
_____ Social Service Data Bases
_____ Treatment Plans
_____ Lab/Radiology
_____ Outpatient Assessments/Evaluations
_____ Outpatient Progress Notes/Treatment Plans
_____ Other (specify) _____

for the treatment period of (list approximate dates):_____

I understand that I may revoke this consent at any time by written notification except to the extent that action has been taken in reliance on it, and that in any event, this consent will expire one year from the date of signature unless an otherwise stated date, event or condition is stated here _____

A photocopy or facsimile of this authorization shall be as valid as the original.

PROHIBITION ON DISCLOSURE (for Alcohol and Drug Abuse records): This information is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. I also understand that I may inspect and, upon payment of the usual fee, receive a copy of the released information, and that I may receive a copy of this intended consent form.

Conditions: This authorization is voluntary. BHD will not condition your treatment on this authorization.

Effect of Granting This Authorization: The protected health information described above may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may not longer be protected by federal health information privacy laws.

_____ Signature of Patient

_____ Date

_____ Witness

_____ Person Authorized To Consent For Patient

Date: _____

Relationship _____
(Legal documentation of relationship required)

Reason: _____

BEHAVIORAL HEALTH DIVISION
Milwaukee, Wisconsin 53226

2194 R11
Rev. 01/06

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION